INVISIBLE CITIZENS

HOME HEALTH CARE WORKERS AND THE PEOPLE THEY CARE FOR

A Special Report from the Labor Relations and Research Center at the University of Massachusetts at Amherst.

Prepared by Christopher Johnson, Mahmood Ketabchi, and Patrick Crowley.

HIGHLIGHTS

* Home health care is the fastest growing segment of the Health Care industry, both Nationally and state-wide.

* Home health care corporations sell themselves as a cost-saving alternative to institutional care. **But this cost-saving is in large part cost-shifting**. The cost burden has been removed from corporate care providers and placed on the shoulders of poor and elderly clients and the people who care for them.

* Shifting costs to the working poor and the elderly may have allowed the state of Massachusetts to cut costs, but it also places thousands of elders at risk and forces tens of thousands of workers to accept poverty level wages.

* Though the number of senior citizens is growing, the State has reduced the number of elders cared for by over 10,000! **Some of these people are not able to dress, bath, or feed themselves.**

* The wages of homemakers and home health aides are tied directly to the state budget. Because of this, people who care for our states grandparents have not had a pay increase **since the beginning of the 1990's**.

* The Health Care corporations the state contracts to care for our elderly have lobbied the legislature to include language in the state budget forbidding any wage increase for home health aides and homemakers.

* Though privatization is supposed to decrease bureaucracy, the Executive Office of Elder Affairs has a **elaborate five-step process** to filter money through private agencies until it finally reaches workers and the people they care for.

* Though Governor Weld wants to "eliminate administrative underbrush" in state government, **the only EOEA department that has received a marked increase in state appropriations is the Administrative Department (up 17% since FY 1994). Funding for services to elders has increased only 2.5% during this same time period.**

* Certain workers have been offered pay increases in the Governor's budget recommendation of FY 1997. **The honest and fair thing to do is extend the 4% raise to the 10,000 home health aides and homemakers funded through the EOEA.**

INTRODUCTION

Through this study of the emerging home health care industry researchers from the University of Massachusetts at Amherst wish to alert the public, the press, and the Commonwealth's legislators to a problem in need of a solution.

The 1990's has seen health care return to the home. But the security and cost effectiveness of this process comes with a heavy price. The number of elderly patients cared for at home through the state's Executive Office of Elder Affairs has been reduced by over ten thousand people. Health Care corporations have forced language into the state budget prohibiting raises to workers making near poverty wages. And the only department to see a marked increase in state appropriations is the Administration department.

We are convinced that this was allowed to occur not because of any bad intentions, but out of forgetfulness. **The state's Senior Citizens and the workers that care for them are our invisible citizens.** They are easy to forget, and the decade of the 1990's proves it.

This report offers a view of our invisible citizens and invisible workers. We first paint a portrait of the industry and environment in which they live and work. We show how they are easily forgotten within the rapidly changing corporate nature of home health care and the privatized state home health care delivery system. Finally, we recommend basic changes to the state budget to insure that the state's invisible workers are no longer forgotten and that the state pay them the respect they have earned.

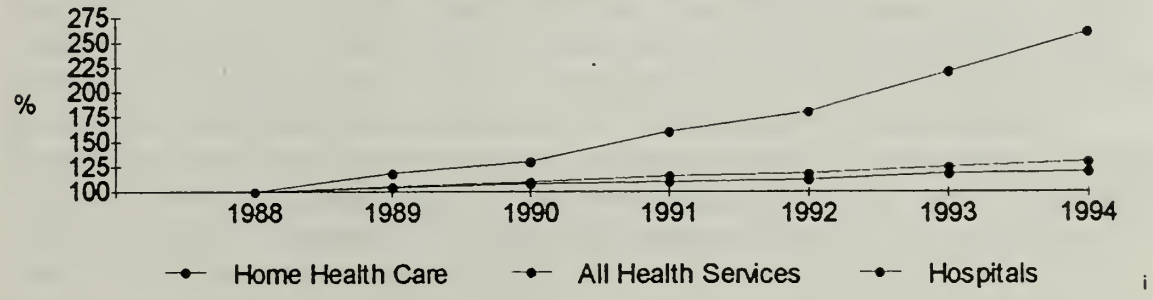
1990'S HOME HEALTH CARE: COST-CUTTING OR COST-SHIFTING ?

A National Overview of the Home Health Care Industry

Having doubled its work-force over the last eight years, home health care is the fastest growing segment of the health care industry. In some respects, this is a return to pre-World War Two practices, when the home was the main site for medical care. But during most of the post-war period, there was an enormous shift towards hospitalization. This trend has been altered over the last decade, however, as new technology, market forces, consumer preferences, and the aging population have made home health care an increasingly attractive option for many people.

RAPID EXPANSION OF HOME CARE JOBS

Employment as a % of 1988 Levels



The home health care industry encompasses a wide range of medical circumstances, ranging from post-hospitalization rehabilitation to assisting the elderly with daily activities and ensuring companionship for our forgotten elders.

An important reason for the explosive expansion in home health care has been the extension of Medicare benefits. The 1988 Supreme Court ruling in *Dugan V. Bowen* clarified the Health Care Financing Administration's policies, resulting in the extension of Medicare benefits to patients that require home health services. After this ruling , the number of Medicare certified home health agencies skyrocketed.[ii]

Technological advances have also allowed for home treatment for problems that once required hospitalization. For example, the advent of equipment that allows glucose monitoring for diabetics from mobile laboratories that can run tests from a van has greatly increased the practicality of home based health care.

The Home care industry can be divided into two broad and often overlapping categories: Custodial care and medical care. Custodial care involves bathing, feeding, shopping, health monitoring, and general companionship that can be crucial to the quality of a patients recovery. Medical services require skills which

enable the health worker to monitor vital signs and body fluids, administer medications, manage tracheal tubes, oxygen supplies, and other related equipment.[iii]

Both segments have had high growth rates and are partially funded by Medicare and Medicaid. This consequently makes both vulnerable to the proposed Republican budget cuts. Because the patients in custodial care are generally low income elders dependent on government funding, this segment could be especially hard hit.

CONSOLIDATION AND COMPETITION WITHIN THE INDUSTRY

In recent years the decentralized nature of the home health care industry has been redefined as mergers and consolidations increase. Health care companies are reacting to industry growth by vertically integrating hospitalization with home came services[iv]. Clinics are forming alliances with home care delivery agencies such as not-for-profit visiting nurses associations. And since the 1980's, hospital associations and for profit agencies have become major players in the market. Some are subcontracting the work to other home care providers while others are actually buying out their competition in the home health segment and operating these agencies as subsidiaries[v]. By doing this, hospitals are developing another source of revenue, retaining control over the patient ,cutting costs by releasing patients earlier and taking advantage of the low wages paid to home health care workers. Now, for-profit agencies make up the majority of home care organizations nation wide.

The trend of mergers, alliances, and vertical integration of care has been touted by the health industry as an effective method of cost containment. But it may not be beneficial to the patients, workers, or society as a whole. The consolidations, mergers, and leveraged buy-outs within the health care have the same effect as they do in every industry. Businesses, in this case, hospitals and nursing homes, close down and are replaced by leaner, meaner models. And because a health care company must take on a burdensome debt when it buys-out a competitor, it forces them to pay even closer attention to the bottom line. Competition replaces care-giving as a companies number one focus.

This is not to argue that the growth of home based care is entirely profit driven/cost shifting. Many patients prefer non-institutional health care. And home care workers provide services that allow patients to stay at home as opposed to moving into a nursing home. But, there are serious costs in shifting health care to workers who are not properly trained or compensated. Home care workers not only suffer from low pay, poor benefits, and lack of full time employment. Their work is often stressful, conducted under dangerous circumstances, and is often unrecognized. Home health care workers often

have to provide their own transportation, putting their own safety at risk. They are the targets of abuse by clients and client family members. This sense of alienation and lack of respect, combined with basic economic concerns lead to turnover rates that range from 50% to 70% per year[vi]. This lack of consistent care certainly does not improve the quality of patient care.

THE HEALTH CARE WORK FORCE

"We are their social worker, nurse, secretary -- the whole nine yards." -Home Health Care worker Serene Burnett

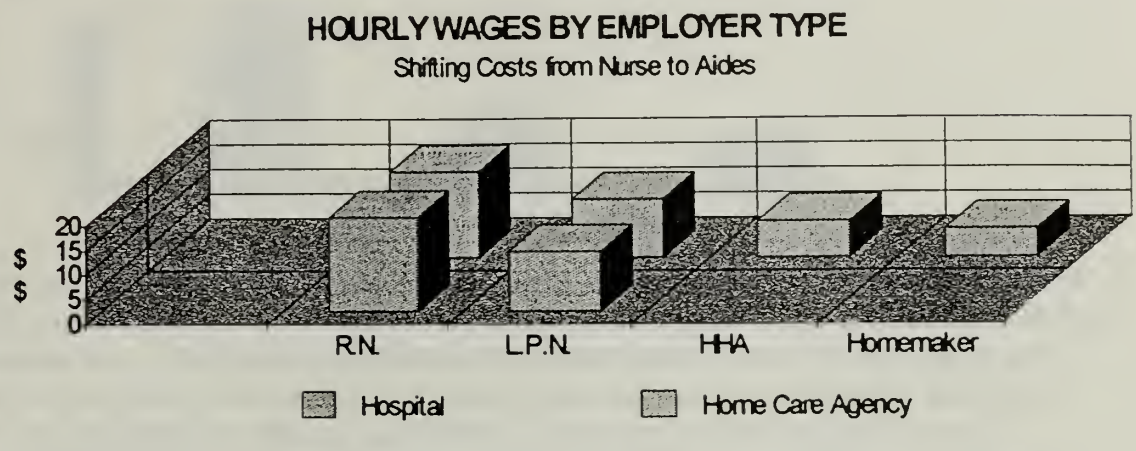
Currently, the shifting of care from institutions to home care is seen as the best way to save capital in order to remain competitive in the health care market. But there is a difference between cost savings and cost shifting. Much of the cost-containment has been achieved by shifting the cost of health care from the institutional provider to the individual worker. By paying home health aides and homemakers ridiculously low wages with little benefits for the work that nurses and doctors used to perform in hospitals and nursing home, health care providers have been able to achieve record profits.

The two main classifications of home health care workers are **homemakers and home health aides** (HHA). Homemakers are involved in custodial care focusing on assisting the elderly and the disabled. The responsibilities include meal preparation, shopping, and transportation[vii]. Most crucial to the physical and emotional well being of the patients is the personal care the homemakers provide, such as feeding, bathing, and grooming. Home health aides provide paraprofessional medical care to patients. This includes monitoring vital signs, assistance with medications, and duties also completed by homemakers. For the home health agencies to receive Medicare reimbursement, the home health aides must have 75 hours of training[viii].

Brief Demographic Profile of home health aides	
Female	93%
Non High School Graduate	38%
Middle-aged	Average Age 47 Years
Single	60%

The shift to home care has also been a boon to states like Massachusetts. By contracting agencies who pay their workers low wages, the state has been able to cut costs. Much of the money that the state provides to their contract agents

remains within corporate offices to cover overheads and increase profits. Only a small amount of the state budget ever reaches the pockets of home care workers.



There are various estimates on home care employment levels, but a reasonable estimate says that between 600,000 and 700,000 workers are part of the home health care industry nation wide. In Massachusetts, there are over 10,00 home health aides and home makers. By the year 2005, the Bureau of Labor Statistics projects the number of home care workers to climb another 128%.[ix]

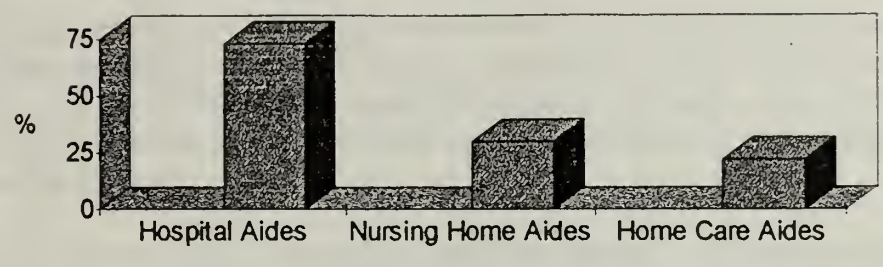
LOW PAY AND LACK OF BENEFITS

Nation-wide, the average hourly wage for home health aides and homemakers range from $7.25/hour to $5.70/hour. As the chart below shows, this places these workers at the bottom of the nations wage scale.[x]

Hourly Wage	Full Year Salary of 40/week	1994 Poverty Level, Family of Four
$7.25	**$15,080**	**$15,141**
$5.70	**$11,856**	**$15,141**

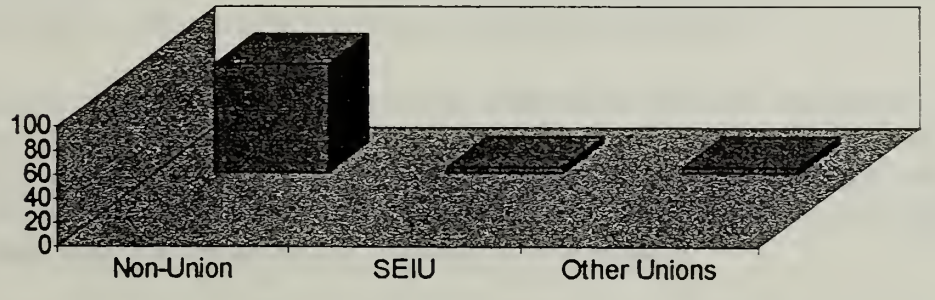
Home care workers are not only paid low wages -- they also receive very little benefits, if any at all. Four out of ten home care aides have no health insurance of any kind. And, two out of ten depend on Medicare and Medicaid[xi]. With the possibilities of federal budget cuts in the Medicaid and Medicare funds, many home care workers are facing not only the loss of their jobs, but also the loss of the minimal benefits these programs provide. Along with this, less than 25% of home care workers have pension benefits.[xii]

HOME CARE PENSION BENEFITS
RELATED TO OTHER INDUSTRIES



This lack of benefits can be attributed to two chief factors: the majority of home health care workers are forced to be part time employees and only 9.6% of them are unionized. The Service Employees International Union is the largest and most active union in the industry. During the first half of the 1990's, SEIU home care membership has grown about 65%. However, even with this flurry of organizing, SEIU still only represents about 5% of home health care workers nation wide.[xiii]

UNION MEMBERSHP AS A PERCENTAGE
OF THE HOME CARE WORK FORCE



HOME HEALTH CARE IN MASSACHUSETTS

" I told them down at the state house one year, ' I hope they don't treat me like they're treating these other people'." - Home Health Care worker Aster Brantley

Following the national trend, home health care in the state of Massachusetts is the fastest growing section of the health care industry. As the health care re-structuring goes on, there will be a continuing shift from institutionalized to individual care. Between 1988 and 1993 in Massachusetts, the annual average employment in home health care services (including homemakers, home health aides, registered nurses, and licensed practical nurses) has climbed from 8,684 to 19,824 workers, an increase of 129%. During the same period, skilled nursing care facilities and surgical/medical hospitals have increased their work

force by only 29% and 10%, respectively. And except for psychiatric hospitals, specialty hospitals have experienced a drop of 1.56% in their work force.[xiv]

A major reason for the continued expansion of home health care providers is the aging population. In 1992, three-quarters (74.1%) of clients were over 75 years old. Out of 10,074 clients aged 85 and over, 72 were over one hundred years old, 832 were over 95, and 3,847 were older than 90. The average age for clients was 80.

In regards to other demographic characteristics, the average age of female patients was 80.2 years; for men it was 78.6 years. About three-quarters of the clients lived alone. Only 6.7% of the clients were from minority groups (though this percentage may be misleading because of different family and community structures among minority communities that may make professional health services unafordable/unnecessary. However, more study must be done in this area).[xv]

Income and need for assistance are two criteria for eligibility for state subsidized home health care. Elders who live alone and have an annual income between $7,232 and $16,442 are required to pay a percentage of the cost of services, ranging from $5 to $105. This also applies to elders living in multiple person households with incomes between $9,565 and $23,266.[xvi]

Moreover, the need for assistance is determined through a system of rankings called the "Functional Impairment Level (FIL)." There are five FIL categories which categorize elders from the least to most frail. For example, elders with FIL 5 are the "least impaired" individuals who cannot perform two to three activities of daily living, such as eating, bathing and dressing.

Even though elders with one of the five FILs are eligible for some home care assistance, there has been a shift towards the most frail ones. Whereas in 1986, FIL 4 and 5 covered two-thirds of all caseloads, in 1993, more than 86% of the case loads were clients in the three most frail categories. In 1994, the two least frail categories were excluded from the state subsidized home health program. As a result, 200 eligible elders were rejected for home care assistance each month following this decision; this excludes all of those who were discouraged to apply[xvii]. It is hard to imagine how a state funded agency would reject a person for care who is unable to eat, bath, or dress her or himself.

" I just go in and I work at a certain speed and I do what I can. I don't rush anything." - Home Health Care Worker Lillie Mae Tabb

Along with a drop in the number of clients served, there has been a drop in the service provided to those who remain under state subsidized care. According to advocate groups, the average number of hours spent with clients per month is

down 5.4 hours, from 19.7 in 1986 to 14.3 in 1992, a 28% reduction in the amount of client service time. These advocacy groups also point out that during this same period, the total number of hours spent in the care of the elderly has dropped from 9 million to 4.9 million, or nearly 47%[xviii]. As a result, many elders are becoming increasingly lonely and isolated.

" This Clustering has got to go- Its going to kill me!" - Home Health Care Worker Aster Brantley

One reason for the drop in the number of hours home health aides and homemakers are allowed to spend with a patient is a practice called "clustering." In the past, a home health aid or a homemaker would be responsible for one patient at a time. Now, as a way of saving money, home health care agencies are forcing workers to perform their duties for multiple clients who live in what is official know as "congregate housing." For example, in the past, if a homemaker had three clients in one area of the city, they would spend forty five minutes food shopping. Now though the Clustering process, which is comparable to an old fashion speed-up on an assembly line, the same homemaker is forced to do the shopping for all three clients within the same forty five minutes. As one homemaker puts it, " after getting to the store, sorting through the lists, dealing with the coupons, welfare checks, and food stamps, I am left with no time to do the shopping for three very different people!"

" Homemakers had been with these clients ten, fifteen years, they (the patients) got sick when the cluster came in . . . those clients get attached to the home health aid and homemaker, and as the cluster came in, they had to pull them away from the clients to serve someone else. Some of them would rather have no homemaker or home health aid." - Home Health Care Worker Serene Burnett

But because homemakers and home health aides develop a strong tie to their patients (some care for the same patient for up to a decade or more!), they still make sure that the shopping and other chores get done right. But, these workers pay a cost for this extra service. Even though they spend extra time making sure the job is done right, they do not get paid for it. Because corporate policy only pays workers for their allotted time, these workers are sacrificing their own time, money, and effort to make sure that our elderly citizens are well taken care of.

In addition to this, services are becoming more de-humanized and impersonal. For example, in a growing number of cases computers are being used to monitor the clients. Because the homemaker is their to add the personal touch , they can encourage the client in a way that a computer cannot. They can make sure

the clients take their medicine, connect a TV antenna that might have become disconnected, find misplaced glasses or dentures. Homemakers and clients develop friendly relationships and bonds that are essential to human life. Homemakers are often the closest thing to family for many of the clients they serve. Human relations and contact that should be the key to home care services are being sacrificed for concepts like cost effectiveness, and profit.

However, home health care workers, who are closely in touch with elderly clients and share their pain as well as their happiness, do not want any reduction in client services. On the contrary, they would like to see these services expanded. They have every reason to be concerned with the lives of the clients because they have a lot in common with them. As homemaker **Aster Brantley** puts it, " I'm 68 years old. I'm old enough for a homemaker myself!." And as **Serene Burnett** adds, " I love my job, I love my clients, but sometimes I ask myself, 'why am I doing this?'"

HOME HEALTH CARE WORKERS AND THE STATE BUDGET

Even though there has been this rapid shift to home health care, many workers in this emerging industry feel stuck in the past. For the 10,000 Home health aides and Homemakers in Massachusetts, poverty-level wages, lack of dignity and respect, dangerous working conditions, and a very real feeling that they have been forgotten by those pushing for a home health care society are all common experiences. But many of these workers are also resilient to this pressure, possessing a fighting spirit and a determination to change things for themselves and the people they care for.

For home health aides and homemakers, there are three key things they seek to accomplish in the fight for dignity, respect, and a living wage:

1. For the state of Massachusetts and their employers to recognize that they are not invisible workers, but human beings.

2. For the state Legislature to remove language in the state budget that prohibits raises, keeping them at poverty levels.

3. For the state Legislature to include language in their budget securing these workers a 4% wage and benefit increase.

" What I'd like to know is -- who is really in charge?" - Home Health Care Worker Amanda Jackson

The wages of many of the state's 10,000 home health aides and homemakers are tied directly to the annual state budget. Though the state maintains the Executive Office of Elder Affairs (EOEA), the Commonwealth's responsibility to care for its disadvantaged elderly is largely privatized. The EOEA maintains contracts with 27 private health care corporations, who in turn contract out their work to 125 Home Health Care Agencies[xix]. So before any employee receives a check, the money must go through an elaborate, five-step process.

STEP ONE: Annual state budget allocation to
STEP TWO: The Executive Office of Elder Affairs, to
STEP THREE: One of twenty seven health care corporations, to
STEP FOUR: One of one hundred twenty five health care agencies,
STEP FIVE: Finally, the paycheck of the worker.

With such a long process, and with so many agencies taking a piece of the money as it trickles down, the home health aides and the homemakers of the state are easily forgotten. "Its like were invisible," says one worker, "we take care of people everyone wants to forget about and the people in charge don't care. This sentiment is shared by many of the front-line home health care workers. **Geneva Evans**, a homemaker who works for the Council of Elders in Boston, says:

> I've spent twenty four years in the system. We do a lot of hard work in this business. We love the work we do, but we have to meet the cost of living just like everyone else does. All I'm going to get when I'm done is a little bit of social security[xx].

Its ironic that for many of these workers who care for the state's most frail citizens, when it comes their turn for special care, they will not be able to afford they same care they gave to others.

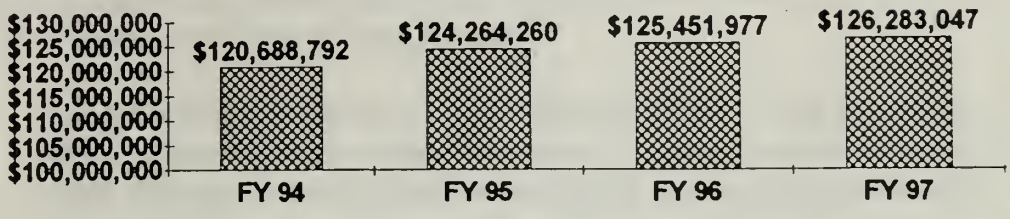
THE EXECUTIVE OFFICE OF ELDER AFFAIRS

The mission of the EOEA is "to ensure the dignity and independence of elderly persons through the development and management of comprehensive, community-based programs[xxi]." Unfortunately, the state has not supplied the money to complete this mission, nor have they recognized the importance of the workers who try heroically to fulfill the mission. During the last four fiscal years, the total budget allocation to the EOEA has risen only 4.6%, not even matching

the cost of inflation.

EXECUTIVE OFFICE OF ELDER AFFAIRS

Total State Appropriation

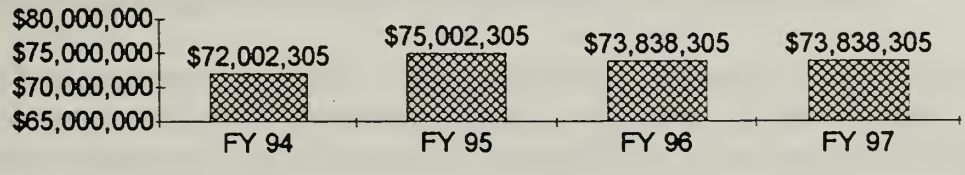


[xxii]

And, during the same four years, the Home Care Account (9110-1630), out of which the cost of services provided to the elderly clients is paid for, has risen only 2.5%[xxiii] .

EXECUTIVE OFFICE OF ELDER AFFAIRS

Home Care Budget



[xxiv]

Even though, the Governor is planning to reorganize the EOEA into four department from nine, he is only planning to level fund the important home care account base on FY 1996 numbers. And, because the home care account is being merged with three other departments, there is no telling if there will actually be a reduction in funds to the home care services. This means that even though more and more people are being forced out of hospitals and nursing home, the state is not supplying any more money for these citizens to be cared for.

STATE SPONSORED POVERTY

The EOEA has set a minimum wage of $7.93/hour for home health aides and homemakers. Because benefits are included in this minimum, the actual hourly wage rages from $5.50 to $6.10/hour. But, because the state has not increased the budget allocation that is to be specifically for wages, and because the state has cut back on the numbers of hours each elderly client is seen by a home health care worker, these workers are often forced to work less than forty hours per week. For non-union workers, sometimes they are forced to work a few as ten to fifteen hours per week. This is barely enough to live on. **Joanne Farrell**, who works at Family Services of Boston says:

> When I get my check the first thing I do is figure out how much goes to rent and electricity. Food comes third. Clothes are next. There's not much to spread around[xxv].

For many workers like Joanne Farrell, it is the language of the state Budget that forces them into these predicaments. During fiscal year 1996, lobbyists representing the 27 Home Health Care corporations contracted by the EOEA forced language into the budget that read:

> **provided further, that no funds shall be expended from this item to pay for any salary increases for direct service workers who provide state-funded homemaker and home health aid services, which would cause a reduction in client services. . .**[xxvi]

For the ten thousand homemakers an home health aids across the state, this corporate sponsored language is a form of "state sponsored poverty." Can it truly be expected that workers who often make less than $160 per week are going to force a reduction in client services? Only if the state supplies very limited resources, which they have done over the last four years.

But this language is based on a false premise. If wages and the level of client services were in an inverse relationship, the number of patients who receive state funded care would have risen dramatically. In reality, the exact opposite is true. In 1988, 45,000 clients were served by state funded home health care workers. In 1990, wages were frozen at the $7.93 level and they have remained there ever since. But, during the seven fiscal years since wages were frozen, the number of clients served by state-funded home health care workers has dropped to 33,800[xxvii] !

It would be economically misguided to assume that the drop in clients served is a direct result in the stagnating pay of the workers who serve them. But that's the logic used by the Home Health Care industry in this state. They try to tie the wages of workers to the number of clients served. This is just not true! It is this fact that most angers a lot of health care workers. The language that controls their wages based upon clients served does not need to be there. That makes the language just insulting.

BUT WHERE DOES THE MONEY GO?

There have been increased allocations to the EOEA over the last four years. But at the same time, wages have remained stagnant and the number of clients served is still far below 1988 levels. So where does the money go? Though one can only assume where the money goes after it leaves the EOEA, there has been one department at the EOEA that has seen marked growth. The administrative budget for the EOEA has grown 17% since FY 1994, up to $2,025,036, based upon the Governor's budget recommendation. Even though the Governor believes " [e]liminating. . . administrative underbrush will make the Commonwealth's government both smaller and better,[xxviii] " he does not seem to

practice what he preaches at the Executive Office of Elder Affairs. As the "administrative underbrush" at the EOEA has been allowed to grow like a weed with a four year, 17% increase, funds to care for the elderly have only increase 2.5% and the wages of workers have not increased in six fiscal years.

And also, following another national trend, the disparity in wages between the people who run Home Health care agencies and the homemakers and home health aides is remarkable. Based upon a sample of salaries, the average annual pay for agency executives in **$71,200, not including benefits**[xxix]. Even if home health aides were able to work a full, forty hour week, they would only be able to make **$16,500, including benefits**, annually.

A RAISE FOR ALL DIRECT SERVICE WORKERS!!

There are signs, however, that the Governor is beginning to see the light about the importance of direct service, home health care workers. Although the Governor's Fiscal year 1997 budget recommendation does not included any language to mandates wage increase for the ten thousand home health aides and homemakers funded through EOEA, other direct service workers are being granted a wage increase. Under the department of mental health, in account number 4910-0310, $2,876,718 "shall be expended to improve salaries for direct care workers...."[xxx] This represents a 4% increase for those home health care workers who care for mentally disabled people.

The home health care workers of Local 285 SEIU are asking the legislature to extend this 4% increase to the workers funded through the EOEA. In order to do this, three important things must happen. **First**, lawmakers must remove the insulting language forced into the budget by lobbyists for the state's 27 Home Health Care corporations. **Second**, lawmakers must put language in the budget dedicating any money for wages be used expressly for the purposes of paying direct service home health care workers. If this language does not exist, even if the legislature wanted extra money to go directly to wages, by the time the money trickled down to the employees, there would be nothing left to go in their paychecks. **Third**, the legislature must make sure that the raise ends up in the workers pockets by not allowing home health care agencies to reduce the number of hours a homemaker or home health aid works. Based on the past experience of many workers like **Serene Burnett**, " they promise us more money an hour, and then they cut the number of hours we work. Either way, we're back where we started."

CONCLUSION

As the researchers were interviewing home health care workers for this report, Serene Burnett, a member of Local 285, SEIU and a homemaker for the Family

Services of Greater Boston, produced a news clipping from *The Boston Globe*. The faded clipping was from a 1987 story reporting how homemakers working for the state were struggling on the low wages they were paid through the state. The story repeats many of the sentiments that appear in this report: Workers feel invisible, they love their clients and they make sure they are cared for even if they don't get paid for it, and they are ready to fight for a pay increase and force the state to pay them some respect.

The fact that almost a decade later, workers like Serene Burnett, Geneva Evans, Aster Brantley, Lillie Mae Tabb, Amanda Jackson and others are still willing to make their voices heard is a testament to their resilient spirit and dedication to their work. But it is also an indictment of those of us who still can't see these workers and patients. **They are not so much invisible as we are blind**.

After reading this report, we hope the Commonwealth's legislators recognize the importance of :

- Removing the budget language prohibiting raises for home health care workers.

- Extending the 4% raise to all direct service home health care workers funded through the Executive Office of Elder Affairs.

- Recognizing that home health aides and homemakers should be paid the respect they deserve for all of their hard work.

This report was prepared by Christopher Johnson, Mahmood Ketabchi, and Patrick Crowley, Graduate Researchers for the Labor Relations and Research Center, University of Massachusetts, at Amherst. For comments, call (413) 545-2884.

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NOTES

1.Laura Freeman, "Home-sweet-home health care," Monthly Labor Review, March, 1995 p5.
2. Laura Freeman, "Home-sweet-home health care," Monthly Labor Review, March, 1995 p6.
3.SEIU Organizing Department and Research Department, "The Home Health Care Industry: An overview", May, 1995 p9.
4.Jay B. Stems, "Emerging trends in health care finance" , Journal of Health Care Finance, Winter, 1994 p4
5.Adriana Jenkins, "Hospitals for-profits enter home care market", Boston Business Journal, February 9-5, 1996 p34.
6.SEIU Organizing Department and Research Department, "The Home Health Care Industry: An overview", May, 1995 p8.
7. Laura Freeman, "Home-sweet-home health care," Monthly Labor Review, March, 1995 p4.
8.SEIU Organizing Department and Research Department, "The Home Health Care Industry:An overview", May,1995 p9.
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